

Mr. Richard Allen
Director, Office of Medical Assistance
Department of Health Care Policy and Finance
1523 Sherman Street
Denver, CO 80203-1714

Dear Mr. Allen:

We are happy to inform you that your demonstration proposal, titled "Consumer Directed Attendant Support" has been approved as project No. 11-W-00136/8 for the period of five years beginning with the enrollment of the first participant. The approval is under the authority of section 1115 of the Social Security Act (the Act).

Our approval of Colorado's Consumer Directed Attendant Support demonstration (and the waivers and Federal matching authority for thereunder) is contingent upon compliance with the enclosed special terms and conditions. The special terms and conditions also set forth in detail the nature, character, and extent of anticipated Federal involvement in this project. The award is subject to our receiving your written acceptance of the award within 30 days of the date of this letter.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable to this letter, shall apply to the Consumer Directed Attendant Support demonstration. Subject to approval of your protocol, as described in the special terms and conditions, the following waivers are granted pursuant to the authority of section 1115(a)(1) of the Act for a period of 5 years beginning with the enrollment of the first demonstration participant.

1. Statewide 1902(a)(1)

To enable the State to operate the demonstration within an area that does not include all political subdivisions of the State.

2. Comparability 1902(a)(10)(B)

To permit the provision of services to demonstration participants that will not be the same in amount, duration and scope as those provided to others in the group.

*' The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS),
We are exercising fiscal responsibility by extracting our stock of HCFA letterhead.*

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3. Provider Agreements 1902(a)(27)

To permit the provision of care by individuals who have not executed a Provider Agreement with the Medicaid agency.

4. Payment. Review 1902(a)(37)(B)

To the extent that prepayment review may not be available for disbursement by individual beneficiaries to their caregivers/provider.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State of Colorado under the Consumer Directed Attendant Support demonstration for the items identified below (which are not otherwise included as expenditures under section 1903 of the Act) shall, for the period of this project, be regarded as expenditures under the State's Title XIX plan.

Expenditures under the demonstration for attendant support services that are provided to demonstration participants by attendants of their choice, which may include family members and spouses.

Expenditures to provide services that are not covered under the State plan as demonstration services, i.e., to provide for consumer-directed attendant support and fiscal intermediary services as part of the demonstration project, and additional health related services.

3. Expenditures for prepayment to demonstration participants for demonstration services prior to the delivery of those services.

Your project officer is Chevell Thomas, who can be reached at (410) 786-1387. Your project officer is available to answer any questions concerning the scope and implementation of the demonstration described in your application. Communication regarding program matters, and official correspondence concerning the demonstration (including continuation applications), should be submitted to the project officer at the following address: Centers for Medicaid & Medicare Services, Center for Medicaid and State Operations, Mail Stop \$2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

We extend our congratulations on this award and look forward to working with you during the course of the demonstration.

Sincerely,

Thomas Scully
Administrator
Centers for Medicaid & Medicare Services

Enclosure

**CENTERS FOR MEDICATE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER:

TITLE:

**AWARDEE:
11-W-00136/08**

Consumer Directed Attendant Support (CDAS) Demonstration Project Colorado

Department of Health Care Policy and Financing

I. PREFACE

The following are Special Terms and Conditions for the award of the Colorado Medicaid Section 1115 Program request submitted on July 18, 1999. The Special Terms and Conditions have been arranged into six broad subject areas: General Conditions for Approval, Legislation, Assurances/Definitions, General Financial Requirements, Monitoring Budget Neutrality, and Operational Protocol.

Letters, documents, reports, or other materials that are submitted for review or approval will be sent to the Centers for Medicare & Medicaid Services (CMS) Central Office Colorado demonstration Project Officer and the Colorado State representative in the CMS Regional Office.

II. GENERAL PROGRAM CONDITIONS

Operational Protocol. The State must prepare one Operational Protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and CMS during the course of the demonstration negotiation, approval, and implementation process. The Operational Protocol, as outlined in Section VI of these Special Terms and Conditions, must be approved by CMS prior to service delivery under the demonstration. The Operational Protocol must contain descriptive and operational aspects of the program to include information, as appropriate, about, at least: the State's organizational structure in place to operate the program, eligibility criteria for the demonstration, eligibility determination procedures, marketing plans and procedures, excluded services, financial responsibilities of enrollees, the State's research and demonstration/evaluation approach and method, and the procedures that the State must utilize to report expenditures and program status. The protocol must be submitted to CMS no later than 90 days prior to program implementation. The Centers for Medicare & Medicaid Services will respond within 60 days of receipt of the protocol regarding any issues or areas that it believes to require clarification.

Prior Approval of Marketing and Enrollment Information. Marketing materials and enrollment information must be reviewed and approved by CMS prior to use. The State may do this by submitting numbers 3 and 4 of Section VI prior to submitting the entire Operational Protocol document, if needed.

Operational Protocol Approval Prior to Federal Financial Participation. No Federal Financial Participation will be provided for Medical Assistance Payments under the section 1115 program until CMS has approved the Operational Protocol. Federal Financial Participation (FFP) will be available for project development and implementation, and compliance with Special Terms and Conditions.

Changes to the Operational Protocol. During the demonstration, subsequent changes to demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

Phase-out Plan. The State must submit a phase-out plan of the demonstration to CMS 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of enrollees should the demonstration be extended by CMS. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than

6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.

Enrollment Limitation During the Last 6 Months. During the last 6 months of the demonstration, new enrollment is not permitted unless the demonstration authority is extended by CMS.

Cooperation with Federal Evaluators. The State must fully cooperate with Federal evaluators and their contractor's efforts if CMS conducts an independent federally funded evaluation of the demonstration program, which may include the establishment and mutual agreement on a comparable control group.

CMS Right to Terminate or Suspend. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and costs not otherwise matchable pending or to withdraw waivers and costs not otherwise matchable expenditures at any time if it determines granting or continuing the waivers would no longer be in the public interest. If the waiver or costs otherwise not otherwise matchable expenditures are withdrawn, CMS will be liable for only normal close-out costs.

State Right to Terminate or Suspend. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the demonstration is withdrawn, CMS will be liable for only normal close-out costs.

III. GENERAL REPORTING REQUIREMENTS

Progress Calls and Reports. Prior to implementation and until 6 months after implementation, CMS and the State must hold monthly calls to discuss progress. During the remainder of the demonstration, progress calls will be held quarterly, however, CMS will be available for additional calls as merited. Further, the State must submit quarterly progress reports that are due 60 days after the end of each quarter. The reports must include, as appropriate, a discussion of events occurring during the quarter that affect program operations, including: enrollment and outreach activities; access and quality monitoring; complaints, grievances, and appeals to the State; numbers of demonstration enrollees; and other operational and policy issues. The report must also include proposals for addressing any problems identified in each report. The State must include a discussion of the content and frequency of these reports in the Operational Protocol (see Section VI).

Annual Reports. The State must submit a draft annual report documenting accomplishments, project status, quantitative and any case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted. The State must include a discussion of the content and frequency of these reports in Operational Protocol (see Section VI).

Final Report. At the end of the demonstration, a draft final report must be submitted to CMS for comments. The CMS' comments shall be taken into consideration by the State for incorporation into the final report. The CMS' document *Author's Guidelines: Grants and Contracts Final*

Reports is available to the State upon request. The final report is due no later than 90 days after the termination of the project.

IV. LEGISLATION

13. Changes in **the Enforcement of** Laws, Regulations, and Policy Statements. All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the Colorado Demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

Changes in Medicaid Law. The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State Section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in New Hampshire, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.

15. Amending the Demonstration. The State may submit to CMS a request for an amendment to the demonstration program to request exemption from changes in law occurring after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration program do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

V. ASSURANCES/DEFINITIONS

16. Adequacy of Infrastructure. The demonstration includes adequate resources to support consumers in directing their own care. The support assures but is not limited to, consumer's compliance with laws pertaining to employer responsibilities, provision for back-up attendants as needs arise, and the conduct of background checks on employees and guidance to consumers on the results of checks.

Assistance of a Proxy. This demonstration is designed to assist individuals who are incapable of directing their own care. Individuals not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.

Supplant Services. Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.

Contract Approval The Fiscal Intermediary (FI) contract(s) will be reviewed and approved by CMS prior to the State's requesting Federal financial payments for expenditures incurred under the contract(s).

20. Staffing. Staff and resources will be made available to prepare the Operational Protocol (see Section VI).

OPERATIONAL PROTOCOL

21. Operational Protocol Content. The State must develop a detailed protocol describing the demonstration. The protocol will serve as a stand-alone document that reflects the operating policies and administrative guidelines of the demonstration. The protocol will be submitted for review and approval no later than 90 days prior to implementation. The CMS will respond within 60 days of receipt of the protocol. The State must assure and monitor compliance with the protocol. The protocol must encompass all requirements specified in the Special Terms and Conditions, including:

Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details about claims processing, dispensing, participant cost sharing collections, and other such details.

Reporting Items. A description of the content and frequency of each reporting item as listed in Section II and III, and Attachment A of this document.

Outreach/Marketing. A description of the State's outreach, marketing, and staff

- training strategy, including: information that will be communicated to providers, potential demonstration clients, and State outreach/education/intake staff (such as social services workers and caseworkers); types of media to be used; specific geographical areas to be targeted; locations where such information will be disseminated; staff training schedules; schedules for State forums or seminars to educate the public; and the availability of bilingual materials/interpretation services and services for individuals with special needs.

Eligibility/Enrollment. A description of the population of individuals eligible for the demonstration (include the eligibility criteria for inclusion and exclusion). Describe the processes for eligibility determination, intake, enrollment, and disenrollment; and the State Agency ..that will be responsible for each of these processes.

Enrollment Limit. Identify the enrollment limit and any process for revising the limit. Also include a description of the procedure for establishing and maintaining waiting lists for participants in the demonstration.

Descriptions or listings must be included for procedures for determining the plan of care; methodology for establishing the budget for the plan of care; how purchasing plans are developed; procedures and mechanisms to be used to review and adjust payments for the plan of care must be described. services which will be cashed out; and, Alternative Health Related Services which may be approved for participants, as well as procedures for amending the description of services.

Education, Counseling, FI and Support Services. Descriptions of the following topics must be included:

- the State's relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal intermediary services; the procurement mechanism, standards, scope of work and payment process for the procedures for ensuring sufficient availability of fiscal intermediary services for consumers who do not pass the mandatory test on employment responsibilities; procedures for mandatory testing of consumers related to fiscal and legal responsibilities and training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities; and,
- the procedures for conducting consumer background checks on potential providers and informing consumers of the results of the criminal background checks.

Quality. Description of an overall quality assurance monitoring plan that includes, but not be limited to the following:

- quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately; case management staff for purposes of monitoring participant health and welfare; quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; procedures for assuring quality of care and participant safeguards;
- procedures for insuring against duplication of payment between the CDAS and AMHC demonstrations, fee for service and Home and Community-Based Services programs; and,
- fraud control provisions and monitoring.

Evaluation Design. A description of the State's evaluation design, including: a discussion of the demonstration hypotheses that will be tested, outcome measures that will be included to evaluate the impact of the demonstration, what data will be utilized, the methods of data collection, how

the effects of the demonstration will be isolated from other initiatives occurring in the State, and any other information pertinent to the State's evaluative or formative research via the demonstration operations.

ATTACHMENT A GENERAL FINANCIAL REQUIREMENTS

The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. The Centers for Medicare & Medicaid Services will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the predefined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).

In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. Applicable rebates and expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9WAIV and/or 64.9PWAIV, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, cost settlements must be recorded on line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of demonstration participants, and those individuals eligible to participate (as described in number 3.c. and d. of this section) that are "also receiving the services subject to the budget neutrality cap. The services subject to budget neutrality include: HCBS Personal Care; Nursing; Home Health Aide; and Homemaker.

For each demonstration year a Form CMS-64.9WAIV and/or 64.9PWAIV will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality cap for demonstration eligibles must be reported. The services must be reported on a date of service basis. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.).

Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VI).

For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. This information must be provided to CMS in

conjunction with the quarterly progress report referred to in number 10 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reponing eligible member/months must be defined in the Operational Protocol (see Section VI).

The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member/months to the total, for a total era eligible member/months.

The demonstration Medicaid eligibility group (MEG) consists of persons residing in the geographic service areas under the demonstration who are using home health agency (HHA) services and for 12 months have utilized at least one service per month.

The term "demonstration eligibles" refers to persons who are eligible in the geographic areas of the demonstration and receiving services subject to the budget neutrality cap, whether or not they are participants of the cashed out feature of the demonstration.

The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State must provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 e. of this Attachment. The Centers for Medicare & Medicaid Services will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the annual grant award to the State.

5. The CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:
 - a. Administrative costs, including those associated with the administration of the demonstration.
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
 - c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.
6. The State must certify state/local monies used as matching funds for the Colorado demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B
MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the AMHC and CDAS demonstrations. The demonstrations will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, the State must be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. There will be one budget limit for both AMHC and CDAS. Procedures for accommodating the potentially different time periods for each demonstration must be included in the Operational Protocol.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Projecting Service Expenditures

Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. The State Fiscal Year (SFY) 2000 base year cost is \$31,966.46 (or \$ 2,663.87 monthly per person cost) and the trended amounts by SFY are the following:

State Fiscal Year

Trended Monthly Per Person
Cost

SFY 2002	\$ 3,385.86
SFY 2003	\$ 3,817.22
SFY 2004	\$ 4,303.53
SFY 2005	\$ 4,851.80
SFY 2006	\$ 5,469.92
SFY 2007	\$ 6,166.79

Demonstration Years which do not align with State Fiscal Years or which fall beyond the range of years shown must be calculated using an annual trend rate of 12.74 percent or a monthly equivalent growth rate of 1.0043 percent.

Using the Trend Rates to Produce Non-Federal Fiscal Year PMPM Cost Estimates

Because the beginning and the end of the demonstration are unlikely to coincide with either the Federal or State fiscal year, the following methodology will be used to produce DY estimates of PMPM cost. Using the monthly equivalent growth rate, the appropriate number of monthly trend factors will be used to convert SFY 2000 base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations

First Demonstration Year:

As an example, assume that the base year (SFY 2000) per capita cost for the enrolled population is \$1,000, and the first year of demonstration (DY 2001) is January 1, 2001, and ends December 31, 2001. Demonstration year 2001 is 18 months in time beyond SFY 2000; therefore, the monthly trend factor must be applied to trend SFY 2000 cost forward DY to 2001. Applying the monthly trend factor to bring the base year estimate forward to DY 2001 results in PMPM cost of \$1079. ($\$1079 = \$1000 \times 1.004233361^6$)

Second and Subsequent Demonstration Years

Since DY 2001 is 12 months beyond DY 2002, 12 months of growth factor are needed. Applying the 5.2 percent growth factor to the estimated DY 2001 PMPM cost of \$1079 gives a DY 2002 PMPM cost of \$1135.

How the limit will be applied

The limit calculated above will apply to actual expenditures for long-term care services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State must subsequently implement the approved program.